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Addressing child welfare concerns: a new approach

In a small proportion of childhood hospital attendances there are obvious child protection issues. In a much greater number there is concern about the child's welfare. Only if concerns are recognised, documented, and addressed at an earlier stage, can we hope to improve ''safeguarding'' children.

In Peterborough District Hospital a ''Concern Sheet'' has been in use since 1998 to address child protection concerns throughout the Trust. Use of the Concern Sheet has been audited twice. Despite this, many failures of documentation, reporting, and follow up were identified. To address these problems, a joint hospital/community ''Children's Liaison and Discharge Coordinator'' was appointed in October 2002. She is a registered children's nurse, with child protection experience.

Our aim was to see if these two measures improved identification, documentation, and follow up of child protection concerns. We retrospectively analysed the Concern Sheet data collected for 2003 and noted a striking increase in child protection awareness in every hospital department where children are seen (table 1). The Coordinator has been very active in raising the profile of child welfare concerns, not just overt abuse, with all staff.

Table 2 shows the causes of concern for different age groups. It is interesting that 25% of reported concerns were about parents and their ability to care for their children. There is a potential risk to children cared for by adults with mental health problems, those who abuse drugs/alcohol, or when there are concerns regarding domestic violence. Hall[1] has stressed that healthcare professionals must take the opportunity to prevent child abuse/neglect when faced with such situations.

We believed that we were addressing concerns which were less serious at an earlier stage, but it is noteworthy only 47 (9.6%) required no further action. Nearly half (230, 46.9%) of the concerns were serious enough to warrant a discussion with Social Services. The Coordinator liaised with health visitors in 229 (46.7%), school nurses in 21 (4.3%), Child and Adolescent Mental Health Services in 29 (5.9%), and police in 40 (8.2%) of the cases where Concern Sheets were completed.

Forty two children (18.2%) proceeded to an Initial Child Protection Conference, 14 (6%) had an early Review Conference, and 2 (0.8%) had an early Transfer-in Conference as a result of the concern reports. Of those subjected to an Initial Conference, 36 (86%) were registered.

From past enquiries into child deaths, the common reasons which have led to a failure to intervene early enough are poor training, documentation, information sharing, and follow up of concerns. Lord Laming[2] has emphasised the importance of better training and introducing systems which allow quality monitoring. We have attempted to address these issues and conclude that ''safeguarding children'' may be improved by:

- Having a person other than the named and designated professionals in the role of a Coordinator
- Having a uniform way of recording child welfare concerns throughout a Trust.

Table 1 Areas of the Trust and numbers of Concern Sheets compared for the years 2002 and 2003

Area	2002 (n = 153)	2003 (n = 490)
Paediatric assessment unit	68 (44.4%)	105 (21.4%)
Paediatric ward	43 (28.1%)	73 (14.8%)
A&E	32 (20.9%)	244 (49.7%)
Special care baby unit	3 (1.96%)	19 (3.8%)
Children's outpatients	3 (1.96%)	11 (2.2%)
Community child health	0	5 (1.0%)
Maternity unit	0	15 (3.1%)
Others*	4 (2.6%)	18 (3.6%)

*As awareness increased, concerns were also received from surgical wards, therapists, and paramedics in 2003.

Table 2 Concerns categorised according to age group

Category	0–4 years (n = 260)	5–10 years (n = 90)	11–16 years (n = 140)
Neglect	102 (39.2%)	17 (18.9%)	15 (10.7%)
Physical abuse	94 (36 .1%)	30 (33.3%)	30 (21.4%)
Sexual abuse	3 (1.2%)	7 (7.8%)	4 (2.9%)
Emotional abuse	0	1 (1.1%)	0
Mental health issues /self harm/overdose	0	2 (2.2%)	37 (26.4%)
Misuse of drugs/alcohol	0	0	23 (16.4%)
Parental mental health issues	20 (7.7%)	8 (8.9%)	10 (7.1%)
Parental misuse of drugs/alcohol	21 (8.1%)	10 (11.1%)	4 (2.9%)
Domestic violence	17 (6.5%)	12 (13.3%)	8 (5.7%)
Others	3 (1.2%)	3 (3.3%)	9 (6.4%)

Each column adds up to 100%.

M Bajaj, R Mease, K Allen, E Dryburgh
Peterborough District Hospital, UK

Correspondence to: Dr M Bajaj, Department of Paediatrics, Peterborough District Hospital, 64 Westwood Park Road, Peterborough PE3 6JL, UK; monikabajaj29@hotmail.com

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Maternal vitamin D deficiency, refractory neonatal hypocalcaemia, and nutritional rickets

We read with interest the articles by Allgrove[1] and Ladhani and colleagues[2] which highlighted the re-emergence of vitamin D deficiency and nutritional rickets as a major public health problem in the UK, especially in the ''at risk'' ethnic minority groups.

We would like to present our experience from a single centre of maternal vitamin D deficiency, neonatal hypocalcaemia, and nutritional rickets. Leicester City has an estimated proportion of 28% South Asians (Census 2001) and an increasing number of other ethnic groups, including an estimated recently arrived 10 000 people of Somalian origin. Studies in our centre have confirmed that significant numbers of south Asian mothers have vitamin D deficiency at the end of pregnancy, and substantial numbers of children have infantile and adolescent rickets, some of whom have extremely severe bony deformities. In addition there have been increasing numbers of late (5–10 days of age) and late-late (2–12 weeks of age) neonatal hypocalcaemia, presenting predominantly with seizures, which, despite intensive calcium and vitamin D treatment have been difficult to correct biochemically. All the mothers had vitamin D deficiency and were supplemented with oral vitamin D and calcium supplements. None of the mothers, despite being within high risk ethnic groups, had vitamin D supplementation in pregnancy despite the recommendation by COMA (Committee on Medical Aspects of Food Policy in UK) that all at-risk pregnant and lactating mothers should receive 10 µg (400 IU) of vitamin D daily.[3] Furthermore, a local audit involving clinicians in antenatal care including general practitioners, midwives, and obstetricians showed that, while health professionals were aware of this issue, there was no clear policy followed.[4]

At birth, the newborn's vitamin D status is directly related to maternal vitamin D status and materno-fetal transfer of vitamin D and its metabolites in pregnancy. Babies whose mothers have a marked vitamin D deficiency will have a compromised vitamin D status,[5] and this has important long term implications for the health of the offspring.[6]

As noted by Allgrove there were national and local ''stop rickets campaigns'' in the 1970s, and in Leicester this appeared to reduce but not remove the spectre of nutritional rickets. In view of our more recent experiences confirming an increasing frequency and severity of neonatal vitamin D

deficiency we would strongly agree with Allgrove[1] and Ladhani and colleagues[2] in emphasising the importance of vitamin D supplementation. It is certainly a serious indictment of our community preventative services not to have protected ''high risk'' mothers and their offspring. We would propose an urgent review and implementation of the national recommendations on vitamin D supplementation in ''high risk'' pregnant women and infants to prevent associated infantile co-morbidity.

S D Shenoy, P Swift, D Cody
Children's Hospital, University Hospitals of Leicester NHS Trust, UK

J Iqbal
Department of Chemical Pathology, University Hospitals of Leicester NHS Trust, UK

Correspondence to: Dr D Cody, Department of Paediatrics, Children's Hospital, University Hospitals of Leicester NHS Trust, Leicester, UK; declan.cody@uhl-tr.nhs.uk

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Competing interests: none declared

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Apnoeas in bronchiolitis: is there a role for caffeine?

Bronchiolitis is a common respiratory illness in infants in winter months. Recurrent apnoeas in high risk infants with severe bronchiolitis increases the need for respiratory support (nasal continuous positive airway pressure and ventilation) and transfer to the paediatric intensive care unit (PICU).[1] During the winter of 2003–04 we had three babies presenting with apnoeas secondary to bronchiolitis. All three babies were ex-preterm infants under 3 months of age. All had deterioration in their respiratory status potentially needing further care in PICU. On advice of two PICU consultants these babies were treated with a loading dose of caffeine. All three showed immediate improvement in their respiratory status and avoided being transferred out. Caffeine is a respiratory stimulant widely used in the treatment of apnoea of prematurity.[2]

Following our experience we performed a questionnaire survey of the use of caffeine for apnoeas in bronchiolitis across 20 intensive care units in the UK. We made a thorough literature search to look at the evidence.

Of the 20 questionnaires sent, only 10 replies were received. Opinion was divided between PICU consultants, with four stating that they would advice a trial of caffeine. This made a total of six, including the two who advised us previously. The evidence from literature is anecdotal.[3]

We conclude that there is little evidence in literature to support the use of caffeine in bronchiolitis, and there is divided opinion in PICUs across the UK. We feel that caffeine is a relatively simple treatment option in a district general hospital for apnoeas in bronchiolitis and recommend a randomised controlled trial. We would welcome comments on similar experiences from readers.

N T Sajit, M Steggall, B Padmakumar
The Royal Oldham Hospital, Oldham, UK

Correspondence to: Dr N T Sajit, Department of Paediatrics, The Royal Oldham Hospital, Rochdale Road, Oldham OL1 2JH, UK; tsnedungadi@yahoo.com

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BOOK REVIEWS

Child public health

Edited by Mitch Blair, Sarah Stewart-Brown, Tony Waterston, Rachel Crowther. Oxford: Oxford University Press, 2003, £29.50, pp 243. ISBN 0 19 263192 6

Since the heyday of public health in the late nineteenth century it has failed to raise the pulse of many clinicians, as they believe its work, at least in the developed world, is done. This book comes on the tide of renewed interest in the discipline.[1] It outlines the current state of child public health, refreshes the contemporary image, and reinforces the premise that child public health is as relevant and important today as it has ever been. Aimed at paediatricians and public health practitioners, it will also appeal to all those interested in the health of children in the UK. For those with little knowledge of child public health it provides an excellent introduction and overview, making accessible the theories and practicalities of child public health.

The book moves nicely from the background, through key concepts, to practical applications. The first three chapters describe the health of children nationally and globally, and outlines how child public health practices sit historically. There is a lot of information covered, some glossed over as a necessity, but generally good use is made of statistics and tables.

The next three chapters give an excellent summary of the theories, key concepts, and techniques used in child public health. Again the pace is swift, readable, and well balanced. The further reading lists adequately guide readers to more detail where required. While it would be easy to be critical about the breadth or depth of topics in this book, it was never intended to be a comprehensive public health reference textbook. However it would be useful to have more on sustainable development, quality assurance/service improvement, and the public health contribution to the commissioning process.

The unique aspect of this book is the inclusion of practical examples of theory applied to prevalent public health problems. After assimilating the basic facts and concepts, the reader is given suggestions on how to put the approaches into practice. The ideas should give renewed hope and encouragement to those at the front line dealing with these all too familiar problems. For future editions it would be valuable to expand the content in this section with a reduced focus on the global context and lessons from the past.

This first edition of child public health succeeds in being readable and making child public health an accessible subject, not with theoretical ideals, but with practical suggestions. We hope this book will inspire a future text, with a wider and more in-depth brief that will become the much needed reference standard text for child public health. However there will always be a place for a book of this length for the reader wanting a summary that can be read cover to cover and digested within a week.

Child public health is a superb book and should be on the shelves of all paediatric, child health, and public health departmental libraries. It is essential reading for all paediatric trainees, but has relevance for all who work in child health, whatever their professional background.

R Tomlinson, S Lenton

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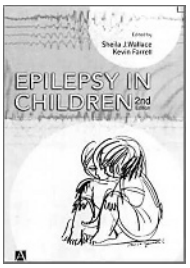
Epilepsy in children, 2nd edition

Edited by Sheila Wallace, Kevin Farrell. Arnold, 2004, £120.00 (hardback), pp 485. ISBN 0 340 80814 4



Management of epilepsy in children can be complex and challenging and a good clinician knows when to draw on multidisciplinary professional expertise, while staying up to date with clinical and non-clinical areas outside his or her immediate expertise. No one understood this more than the late Sheila Wallace under whom I had the privilege to